Sleepy Eye Medical Center

400 4th Ave NW
Sleepy Eye, MN 56085-1109
877-794-3691

APPLICATION FOR FINANCIAL ASSISTANCE

In order for Sleepy Eye Medical Center to process your application, all sections must be completed. Along with your application, please submit the following documents for all members of your household so we can verify your financial situation:

- Bank statements (last two months)
- Pay stubs (last two months)
- Most recent tax returns

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information

Applicant Name: ______________________________ Date of Birth: ___/___/_____

LAST NAME FIRST NAME MIDDLE NAME

Address: ____________________ City: ____________ State: ______ Zip Code: __________

SSN: ____________________ Phone Number: (   ) ____________ Email: ____________

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.

For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

Additional Family Member Name(s) Date of Birth Relationship to Applicant

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

SECTION THREE: FINANCIAL INFORMATION

Please provide any income that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Employment Income		
All Other Income Sources		

If there is no household income, please use this space to explain how you are being supported:

SECTION FOUR: INSURANCE INFORMATION

Please provide your health insurance/medical coverage information, if applicable.

Name of Insurer: ____________________ Subscriber ID Number: ____________________

Subscriber Name: ____________________ Group Number: ____________________

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay my medical expenses. I understand that the information provided may be verified, and I authorize Sleepy Eye Medical Center to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s). I grant Sleepy Eye Medical Center permission to contact me using any method provided on this application.

Signature of Applicant: ______________________________ Date: ____________________